MHDS Redesign Adult Mental Health Workgroup

Meeting #1
August 23, 2011, 10:00 am to 3:15 pm
United Way
Des Moines, IA

MINUTES

Attendance

Workgroup Members: Becky Cleveland, Teresa Bomhoff, Chris Hoffman, Kathy Stone, Dr. Michael Flaum, Patrick Schmitz, Gilbert Cerveny, Jerry Bartruff, Dr. Bhasker Dave, Deb Albrecht, Dr. Christopher Atchison, Chuck Palmer

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Jack Hatch, State Senator, Senate District 33 (Polk County) Co-chairs of the Legislative Interim Committee on MHDS Redesign

Facilitator: Kevin Martone, Technical Assistance Collaborative (TAC)

DHS Staff: Theresa Armstrong, Dennis Janssen, Laura Larkin, Joanna Schroeder, Jeannie Kerber

Other Attendees:

David Adelman	Iowa Academy of Family Physicians
Kris Bell	Senate Democratic Caucus Staff
Josh Bronsink	Senate Republican Caucus Staff
Linda Brundies	Iowa Ombudsman
Dawn Clark	Social worker-Wapello County CPC
Braden Daniels	Iowa Office of Consumer Affairs
Michelle De La Riva	Richmond Center/Community and Family Resources
Deb Dixon	Iowa Dept. of Inspection and Appeals
Sara Eide	Mercy Health Network
Kris Graves	No affiliation
Linda Hinton	Iowa State Association of Counties (ISAC)
Todd Lange	Iowa Office of Consumer Affairs
Barbara Murphy	ABCM Corporation
Todd Noack	Office of Consumer Affairs
Liz O'Hara	Center for Disabilities and Development (CDD)
Brice Oakley	Iowa Alliance of CMHCs
Kelley Pennington	Magellan Health
Jessica Perry	Hillcrest Family Services/Peer Support Training Academy

Chris Petersen	Abbe Center/Iowa Advocates for Mental Health Recovery
John Pollak	Legislative Services Agency (LSA)
Carol Porch	Community Mental Health Center
Lorri Regan	Hillcrest
Donna Richard-Langer	Department of Human Services (DHS)
Lisa Robin Sanford	Iowa Office of Consumer Affairs
Nicole Schultz	Iowa Pharmacy Association
Deb Eckerman Slack	Iowa State Association of Counties/County Case Management
Julie Smith	Iowa Health System
Kim Scorza	Seasons Center
Bob Thacker	Northeast Iowa Behavioral Health
Deanna Triplett	Iowa Behavioral Health Association
Jennifer Vitko	Wapello County CPC
Karen Walters-Crammond	Polk County Health Services
Michelle Zuerlein	United States Psychiatric Rehabilitation Assn. (USPRA)

Agenda

Agenda Topics:

- Workgroup Overview and Introductory Remarks
- Initial discussion of eligibility criteria
- Meeting Summary and Assignments for next meeting
- Public Comment

WORKGROUP OVERVIEW AND INTRODUCTORY REMARKS

Introductory remarks by State Representative Renee Schulte:

- In the past five years, Rep, Schulte has been listening to people expressing their concerns about the mental health system; she expressed that change is difficult
- Need to identify strengths and what needs to be changed
- The workgroup has the information from all of the reports-now is the time to implement as there is bipartisan support and involvement
- Huge opportunity to have public input into the system, as opposed to just legislators and government staffers making decisions

Topics that Rep. Schulte identified as needing to be addressed:

- Functions of MHI's-how should they fit into the continuum, what is their role in the System of Care, are they truly the place of last resort?
- Is it a bed capacity issue or just the wrong people in the wrong places?
- Identification of best practices, core services that are flexible and equitable in a Regional structure
- Medical home model-consider medical issues as well as mental health issues

Introductory remarks by Senator Jack Hatch

- Creating laws is a difficult but worthwhile endeavor
- The legislators are here to pass the work on to stakeholders
- The end result should be a body of legislation that can be acted on in January 2012
- The legislature built repeals of county based system into the legislation- the State has to have new legislation to replace it with
- Sen. Hatch stated that there are some good programs but access to services is sporadic and not equal
- Sen. Hatch complimented DHS for working with the legislature on the redesign efforts

2011 Legislative Session:

- Senate File 525 calls for reform of the mental health and disability services system in Iowa
- Senate File 209 sunset the Code creating the mental health tax levy and central point of coordination provisions beginning July 1, 2013 with the intent to move reform forward

Why is reform needed?

- County property tax levy rates have been capped and most counties are levying to their maximum
- Iowa's county of legal settlement system for financial responsibility is outdated
- "Transactional friction" exists in the payment and administrative structure of the system
- Iowa has recently moved to a statewide waiting list
- Geographic inconsistencies and inequities in access to services exist

The goal of redesign is:

- To create a core level of services that all Iowans can expect no matter where they live
- To create flexibility for regions to be creative and make choices in how they might want to go beyond the core level of services

Introductory remarks and workgroup role and membership issues-DHS Director Chuck Palmer:

- The workgroups will be covering a lot of material in a shortened timeframe
- Groups will interface-the Intellectual Disability and Mental Health workgroups will do the same type of work-identifying core services, funding, eligibility criteria
- Legislative intent-legislators provided blueprint and conceptual framework. Now the workgroups task is to flesh it out but stay true to intent
- Interim Committee will begin their work in October, how they will turn work into legislation

- This is not a planning process, this is an implementation process to develop recommendations that can become legislation
- Governor Branstad heard a great deal of concern from the public about the Mental Health and Intellectual Disability system during campaign
- Need to be awareness of co-occurring issues
- Effects of broken system evidenced by influx into corrections which is not equipped to deal with these issues
- Court workgroup is identifying transportation and pre-screening as issues - recommendation will be that it will be a core service
- Issues of transportation and access to psychiatric inpatient care, leading to law enforcement driving across the state looking for a psychiatric bed when people are committed
- Meeting of two committees so far-Children and Regional
- The Children's Disability Workgroup will be addressing the out of state placement of children issue, who are they, why are they placed out of state

Introductions of workgroup members

Overview of the workgroups

Redesign Workgroups:

- Regionalization
- Adult Mental Health Services
- Adult Intellectual Disability and Developmental Disability Services
- Children's Services
- Brain Injury
- Judicial Branch/DHS

Workgroup Formation:

- DHS received many applications for workgroup membership
- Including the Judicial Workgroup about 88 people are involved
- A few additional members may be added
- Workgroups to look at PMICs (Psychiatric Medical Institutions for Children) and information technology will also be convened
- Each group has a lot of work to do and meetings will be structured with subject matter defined for each session

Public input into the process:

- Workgroup meetings are open to the public
    - Time will be reserved at the end of each meeting for public comments
    - People who are observing are asked to hold their comments or questions until that time
    - Please limit them to the subject matter of that day's meeting
    - Please keep them brief and to the point

    - Please do not repeat comments that have already been offered
- There has been significant interest on the part of consumers, patients, and advocates in participation in this process
- DHS is sensitive to consumers and family members having an effective avenue to be heard
- Individuals may be invited to provide information to workgroups from time to time

Introductory remarks by Kevin Martone, Facilitator, Technical Assistance Collaborative

Kevin Martone shared handouts:

- Agenda for today's meeting-locations have been clarified-information is correct in handouts and website
- Proposed agenda for future meetings
- Meeting Schedule
- Workgroup membership list
- Summary of Senate File 525
- Instructions for accessing the website-documents are available to the public that are provided to the workgroup
- Description of sites for meetings

Joanna Schroeder is managing the workgroup meeting process for DHS.

Technical Assistance Collaborative:

- Kevin works for the Technical Assistance Collaborative (TAC), a non-profit with offices in Boston; he was formerly the Deputy Commissioner for the State of New Jersey overseeing the entire mental health and substance abuse system, as well as other functions at the department
- Kevin was also the president of the National Association of State Mental Health Program Directors (NASMHPD),also has worked in supported housing and clinical work
- TAC works with federal, states, and local government and non-profits all over the country
- TAC was formed 20 years ago with grant from the Robert Wood Johnson Foundation to work with states and counties around the issue of health reform
- Since then TAC has worked with 48 states and many localities on issues of getting good practice services to people with disabilities and mental health conditions
- TAC's primary mission is to work on behalf of people with disabilities to figure out the best ways to manage and access resources; they have also worked with CMS (Centers for Medicare and Medicaid Services) and SAMHSA (Substance Abuse and Mental Health Services Administration)
- Experienced working in Iowa with DHS, ISAC (Iowa State Association of Counties) and individual counties

Kevin's observations on the redesign efforts and process:

- Legislative involvement and support is important, this is unheard of in other states, commends the Iowa legislature for their support and involvement in the redesign process
- Iowa like other states is dealing with financial pressures-issue of how to pay for recommended core services, may have to phase in new services or changes over time
- A large amount of information has been gathered already, challenge is to process and share that information effectively
- The first conversations will be on eligibility and then will move onto core services.
- Eligibility issues-a state or system could serve more people but not as intensively, or tighten eligibility so that fewer people are eligible for services but does this allow enough flexibility for individual needs beyond what is commonly available
- For perspective, group should consider whether the system will be developed from an inclusionary or exclusionary perspective
- Health care reform will affect individuals eligibility also
- Initial eligibility doesn't mean that you are eligible for everything-a person may want ACT but doesn't qualify for that type of service-eligibility and core services need to be aligned
- Decision trees can be an important tool-how to identify who gets what services How can we make the system as equitable as we can?
- The public mental health system has to provide a safety net service regardless of income, and then can determine eligibility afterward
- An individual may be eligible for Medicaid but does that carry over to eligibility for non-Medicaid services? The intent of the legislation is to look at standardizing eligibility for services

Workgroup members' comments

- There is a difference between safety net service, vs. categorical eligibility for services
- Eligibility means who is eligible for services in the overall system, but the word "eligibility " is also used to identify who receives specific services
- Questions were raised regarding who and where eligibility would be determined; eligibility determination at the point of service was supported by the group
- In Linn County, the county does determination of eligibility and the CPC provides the service coordination
- Certain adult males are not eligible for Medicaid but those individuals need to be included in the system
- Question of whether the group is to identify financial eligibility as well as other components
- Currently, clients start services immediately-provider does paperwork and sends to CPC
- Issue of undocumented individuals needing mental health services

- Director Palmer said that the undocumented issue should be in the parking lot, hospitals are also struggling with how to serve them in the acute care setting

Discussion on definitions of Serious Mental Illness (SMI) and Chronic Mental Illness (CMI)

- Discussed the definitions of CMI as found in Iowa code and in the State Mental Health Block grant definition of SMI used by Iowa (SAMHSA definition)
- Discussed New Jersey definitions of target population; goal is to serve anyone in need, then identify higher priority groups such as those who are at risk of hospitalization
- Massachusetts-has more detailed eligibility criteria including limiting services to those with certain diagnoses, co-occurring, and functional Impairment
- Other population to consider is youth aging out of the system as well as protocols for people who don't meet the criteria
- Washington- Has specific guidelines for eligibility; basic eligibility and then identify what level of services a person may qualify for - also says a person has to be able to benefit from the service and not funded elsewhere - uses GAF scale as part of functional assessment
- Wisconsin has newer web-based system for eligibility-has built in logic model, guides toward using correct services for what the person's eligibility is; more accountability for funds - also used for Intellectual Disability and Developmental Disorders and substance abuse

Questions from the facilitator: How important is diagnosis to eligibility? How do we determine financial eligibility? Should financial eligibility level be the same across all of the delivery systems? How does the group want diagnosis to play into eligibility-should it be the SMI determination or diagnosis of a specific mental illness? Should CMI and SMI be merged into one definition?

Group comments/discussion

- Regarding eligibility defined by diagnosis -what happens to those who don't meet criteria but need services
- Facilitator responded-through functional assessment, services could be identified
- A workgroup member worked in Texas which has a similar system-based on diagnosis and GAF; a concern is that as people get better they may not continue to qualify for services due to rising GAF scores
- It's important to have a continuum of core services available to meet people where they are at
- Compare where we are now with where health reform will take us
- General consensus that a broader definition should be used for eligibility when it comes to diagnosis
- Counties are mandated to serve individuals at 150% of poverty level and $2000 in resources
- How many counties are above 150%-nobody knows for sure but it has been decreasing
- Is 150% a reasonable level to determine eligibility?

- The financial eligibility for Substance Abuse Treatment is 200% of poverty level; would it make sense for it to be the same across systems?
- General consensus that financial status should be considered and should be the same across all regions, right now some counties cover above 150% and some don't; 150% reasonable, but should consider being consistent with substance abuse
- Providers need a sliding fee schedule that goes above the 150% limit-right now it is all or nothing-if above the 150% limit, no services are funded
- Some counties go to 350%-but even then people have a hard time paying due to other bills or poor insurance
- General consensus that there should be a standardization sliding fee with caution taken to ensure that variables beyond just income (e.g. children) are considered
- Private insurance may cover a limited number of sessions
- High deductibles lead to bad debt for the mental health center
- In some areas, if you have insurance you are automatically not eligible for services, even if the insurance doesn't cover mental health
- Mental health parity is partial, biological based, individual policies and small groups covered in parity

- Director Palmer commented-the legislation changes who is negotiating with whom-the workgroup is to make recommendations on a state system-money would be flowing from the state to the regions operating on consistent rules, then the regions contract with local providers .The question is will the sliding scales for each region look the same, and how will sliding scales apply to other types of providers besides CMHC's?
- Rep. Schulte stated that the group can create rules on how to address the challenges of underinsured/uninsured
- Be mindful of best practices around employment disincentives-some people stay eligible for services by staying unemployed
- Eligibility for Medicaid based on income, not based on assets under Affordable Care Act may be an incentive for more people to work
- There should be a broader definition than the Massachusetts example- functional impairment also is important to determine what services are needed
- Concern about limiting or excluding diagnosis such as adjustment disorder-because it excluded the problem could become worse and more costly to the system
- The system shouldn't worry as much about primary diagnosis, especially in co-occurring situations where the agency is treating both conditions. CMHC's don't get credit for treating individuals and preventing hospitalizations. The state of Texas went to restrictive eligibility criteria-no AXIS II diagnoses allowed except for crisis services and his pushed those individuals in to high utilization of crisis, instead of ongoing care
- Comment from Rep. Schulte-legislators don't need to dictate diagnosis
- Group supported one definition for SMI/CMI
- Facilitator commented that there is a struggle in systems between providing prevention and early intervention, and serving the CMI high needs population;

there is also a financial issue-person who needs basic outpatient vs. a high utilizer –how to determine who gets what

- There need to be a means of identifying the target population vs. all MI consumers
- There should be a continuum of services, the target population should based on needs as well as funding eligibility
- There is a concern about if this will delay services until people are in crisis
- Facilitator commented that how much priority to put on different types of services and how the dollars are allocated will have to be identified-eligibility standards will also drive this and recommended that the group follow a two step process:

  Step 1-develop a broad definition of individuals in need of basic mental health services

  Step 2-Utlize a functional assessment process to further define eligibility for specific services

  Director Palmer reminded the group to not let financial issues limit ideas for best practice proposals- start with what is right, smart, and best practice. Financial issues can be dealt with during the legislative process.

Group comments

- Rural CMHC offices struggle with volume needed to maintain offices at the level counties would like-who will decide what the provider panel is-will it be any provider or only CMHC
- Question about what the income limit is under Affordable Care Act. Facilitator responded regarding the ACA question-the limits are 133-138%. Follow up question from workgroup member of why we wouldn't use the same limits. The answer was that it would exclude people who are currently served at 150%.
- Question about recovery services- Kevin says this will be covered in core services discussion

Director Palmer response-

- The regional workgroup did not discuss was focused on what types of services should be available in a region and the workforce issues and capacity in a region. He thinks it will fall to the regions to decide whom to contract with.

- IME projects 150,000 new people will be eligible under the ACA. There is a major impact to the system by adding them to Medicaid and taking them off the county rolls. This will place additional burden on the workforce to serve increased numbers, which brings the question, what is the capacity of the system? The workgroup has to think about plans with and without Affordable Care Act.

Functional Assessment Discussion –Mandates regarding types of tools used across the state or regions, where will it be administered, presumptive eligibility issues

- Dr. Flaum summarized past work on Functional Assessment-Jan Heikes, Lynn Ferrell, and Dr. Flaum, among others were on a Functional Assessment workgroup 6-7 years ago
  Three levels of assessment were identified:
  1. Financial and clinical-is the person in need of services or not
  2. Continuum of need from basic to most severe-matching needs to services
     Level 2 includes use of a standardized tool-LOCUS was identified for as a preferred tool for mental health
  3. Person centered planning-specific to the individual
- The functional assessment is for decision support, not a decision making tool; it should not punish people for improving by causing a reduction in supports when improvement is measured
- There has been concern expressed about the potential conflict of interest regarding the agency who wants to be reimbursed for services, completing the assessment that will determine eligibility for services (the fox in the henhouse issue)
- Questions to the group from the facilitator- Does the Region complete the functional assessment or the provider? How do we ensure that we are moving people through the system, measure outcomes and quality, examine utilizations patterns across providers, looking at high utilizers as well as low utilizers?
- Response from Director Palmer- The region is a management entity, not providing any direct service. The region is responsible for following state policy and accountable for the local delivery system.

Group comments

- Keep it limited to the least amount of providers as possible-help individuals in one place as much as possible- ensure that there is no wrong door-do as much eligibility and assessment in one place as possible
- Keep the system welcoming- should not be designed to exclude people
- Concern was expressed about if the results of a functional assessment could be used to keep people out of the system
- Residency rules are an issue at the state level, law is broad

Legal Settlement Discussion

- Discussion of change from legal settlement to residency as the new law did away with legal settlement

Group Comments

- We don't want to create same issues in a region as there are in counties-if you live closer to a provider in one region but live in another so can't be served where it is more convenient

- The provider's goal is to help people regardless of residency status or potential diagnosis

Core Services Discussion

Questions regarding what types of services should be included, how does functional assessment help guide types of services offered, will there be controversy regarding what is included or not included as a core service?

Core services can be identified in these categories-from SAMHSA

1. Prevention
2. Early intervention
3. Treatment
4. Recovery supports

- Short term crisis case management, being used in Iowa City, group should think about if this is a core service
- This group should also be looking at crisis stabilization and jail diversion
- How does a person coming out of corrections establish residency
- The system should be able to intervene at multiple intersections
- Question was posed to the group regarding using one standardized assessment tool across the mental health system, if there is any reason why this should not be done? If so, who is responsible? General consensus that one standardized assessment should be used statewide
- The expectation is that there would be guidance on how to use the tool, who will use the tool
- The system needs a Level 2 Functional Assessment to allocate resources and services wisely, not to make immediate clinical decisions
- Group wanted more information on standardized assessments
- DHS wants comment from providers on why or why not to use a standardized tool
- What tool is Magellan using? Is that a tool that can be used? Should it be consistent between the systems?
- LOCUS can be tested by the public on the DHS website
- Substance abuse should be considered in the functional assessment; IDPH discussed ASAM criteria to guide service needs
- What are the services to include and to not include, what are we trying to achieve in the system? Basic elements are use of best practices, based on Olmstead principles, acute and subacute levels of care, what else should be included?
- Need to define what outpatient means, how detailed should the description of core services be-should the different types of outpatient services be described individually
- The group was referred to the SAMHSA Good and Modern service system for assistance in identifying core services and a NAMI matrix of services.
- Director Palmer responded that the group needs to be as detailed as possible to assist in rule making processes

- The core services defined in the Chapter 230A revisions were mentioned as a starting point for identifying core services
- The group was encouraged to consider trauma-focused care, prevention, recovery, co-occurring services, and the interface with health care in their consideration of what constitutes core services
- Peer support services were also identified as a potential core service
- County issue of mandates for funding of certain services were not all removed by the repeals in the legislation, such as county funding of institutional care for the intellectual and developmental disability population
- This drives funding toward those mandates, even if it is contrary to stated goals
- This mandate is completely contrary to Olmstead principles
- Group was asked to be aware of potential core services mandate results-could it lead to more institutionalization
- Employment and housing services could make a huge difference to help people remain/attain stability
- This will be a huge shift in the system if this happens
- New services have been developed since the current laws and mandates were made such as Assertive Community Treatment
- Supportive education, peer delivered services more prevalent in other states; the group should keep in mind what the Department of Justice is doing in other states regarding institutional care
- Access to Recovery for substance abuse- has been working with nontraditional providers to provide the supportive services
- Indiana model of regionalization-same core services in every area but may look differently in rural vs. urban areas
- ACT programs take the service to the client, clients more likely to participate, don't limit to partial and day treatment programs as clients don't always want to come to a center several days a week for hours at a time
- If you add in a new service or requirement, need to take something away
- Crisis stabilization and 23 hour beds should be included
- Workforce issues are a concern, are practitioners practicing within the scope of their practice-if services are mandated but there are no providers available, then what happens?
- Telehealth and distance treatment should also be considered
- The group agreed that ACT, peer support, and acute care were not controversial
- Potential controversial issues were: role of case manages, what is their scope of practice, how does care coordination compare to case management?
- Provider utilization of electronic health records to improve coordination of care is important
- Issue of core services in counties- how does the county that has fewer resources and those that have more equalize without people losing access to services currently available?
- Supported housing a best practice- question was asked if Magellan paid for housing? Kelley Pennington responded that they cover services but not typically things like rental assistance

- A rent subsidy may be a valuable service to be funded even though it's not a core service
- If there are things we know work like supported housing-how do we include them in the system?
- Transportation also an issue and a barrier to services
- Reference to the SAMHSA good and modern document regarding bidirectional integration of primary and behavioral health care–how will medical care be integrated into CMHC or Substance Abuse Provider agencies, or vice-versa
- There is a National Council paper on quadrants of services-who becomes the primary provider of care when people have multi-occurring issues
- Other states are trying both ways of bidirectional integration-suggestion to build on what Magellan is doing with integrated health homes; other states are also looking at moving their high utilizers into health homes
- People may stay in a higher level of care because there is nothing else available and they don't want to lose the supports they have
- The regional structure will have formal budgets that they will have to live with, this will encourage utilization management, however, regions may apply for grants or other funding to support additional services

Final questions for the group

- What are the components of core services?
- If you designate a service as core, who gets it, why, and how do they move out of it?

NEXT STEPS:

Information requested for next meeting:
1. Functional Assessment workgroup report from 2006-2007
2. Information about the LOCUS functional assessment
3. Comparison of core service requirements across current systems
4. Financial eligibility and sliding scale proposal agreement will be brought to the next meeting
5. How many counties are funding services for individuals above 150% of poverty level?
6. How many people in Iowa are at or below 150% of poverty level?

Meeting 2 Agenda:

- Best practices and trends regarding core services
- Discussion of a modern system of mental health services (SAMHSA paper)
- Core services key decision points
- Core services workgroup recommendations
- Recommendations related to crisis and sub-acute capacity

MEETING SUMMARY:

- Introductions
- Discussions around the following topics-
    - Definitions of Serious Mental Illness/Chronic Mental Illness

- Other states eligibility determination standards
- Eligibility for services-financial and clinical
- Standardization of eligibility criteria across behavioral health systems
- Functional Assessment as part of eligibility determination
- Residency/legal settlement
- Definition of core services

PUBLIC COMMENT:

Comment: Consider community and private sector programs already available and teaming up with them so available services are accessed in a coordinated manner. An example was provided of a person who expressed suicidal intent without a plan and was denied admission to a hospital without being linked to a community suicide prevention program.

DHS Response: This comment speaks to how a core service is operationalized and carried out within a region and making sure that services are coordinated.

Comment: Iowa has rural areas and very rural areas. Cutting edge and new ideas are needed such as funding peer support, telehealth, and crisis stabilization services that keep individuals out of hospitals but are supported by grants in addition to third party reimbursement.

Comment: 1. SF 525 includes core services in the 230 A revisions for CMHC-this should be a reference point for discussion of core services.
2. The workgroup should be educated about workforce issues. More time is needed for providers to talk about credentialing, service issues, provider accreditation-make some decisions on which providers can do which services.

Comment: The redesigned system should have ability to fund nontraditional supports like gym memberships or activities that help support a person's physical health as well as their mental health.

Comment: A concern was expressed about people losing services when they improve and then having bad days and still needing help,

DHS Response: DHS acknowledges people will have remission.

Comment: People on other waivers have access to Consumer Choice Options but individuals with mental illness do not. This would help fund some of the nontraditional services that help support recovery. Other states have funded it. Iowa needs more self-direction and CCO options.

DHS Response: People want to direct their services.

Comment: Electronic health records will help tie services together, identify what works, connect providers across the state, provide better quality, and coordinated care.

Comment: Supported housing provided by Vera French is a good example of a service that helps individuals with mental illness live in the community. The program may have outcomes to share.

Comment: An issue regarding housing was identified in the ID system and the Money Follows the Person grant. There have been issues regarding getting landlords to accept clients who are moving from institutions back into the community. What are the strategies that should be used for all individuals with disabilities to access housing? Iowa Finance Authority has been very supportive and interested in supporting this effort. The housing efforts also support Iowa's Olmstead goals.

Comment: Recovery based services should be infused in core services. Services should be consumer driven and can be consumer provided. Peer support is an empowering gateway into employment for individuals in recovery.

Comment: This person has worked with NAMI at the state and national level and believes in power of education. Clients and family members don't always know their diagnosis so can't be a strong part of their own treatment. A concern was also expressed about inequality among different counties' services.

Comment: A statement of appreciation was made regarding the presence of the IDPH Director of the Division of Behavioral Services on the workgroup to represent the substance abuse treatment system. Financial eligibility should be consistent between IDPH and DHS as many programs provide services to consumers from both systems and support increased consistency among the service systems.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.